88-640

No. 88-

Supreme Court, U.S.
FILED
OCT 14 1988
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

EMPIRE BLUE CROSS AND BLUE SHIELD
AND
BLUE CROSS AND BLUE SHIELD ASSOCIATION,
Petitioners,

v.

THE UNITED STATES,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

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October 14, 1988

PRESS OF BYRON S. ADAMS, WASHINGTON, D.C. (202) 347-8203

QUESTION PRESENTED

In a dispute between the government and a private party, do the requirements of due process permit an administrative tribunal to hold an evidentiary hearing limited to consideration of one legal basis put forward by the government to support its position, and then decide against the private party on a different basis, not advanced by the government before or during the hearing and as to which the private party was given no notice or opportunity to present evidence?

PARTIES TO THE PROCEEDING AND STATEMENT PURSUANT TO RULE 28.1

Though all parties are named in the caption, the following further explanation may be useful to the Court.

Petitioners are (1) Empire Blue Cross and Blue Shield ("Empire"), a New York non-profit corporation, which is the Blue Cross-Blue Shield organization or "Plan" serving 28 counties of New York State, including the New York City metropolitan area, and (2) Blue Cross and Blue Shield Association ("BCBSA"), an Illinois non-profit corporation, which is the national association of Blue Cross and Blue Shield Plans. Empire is a member of BCBSA.

Empire is the product of consolidations and mergers of several predecessor non-profit corporations. The most important of these for present purposes was Associated Hospital Services of New York ("AHS"), which during the periods here involved was the Blue Cross Plan serving New York City and other southern counties of the state. Because AHS was the key entity for purposes of this case, we will usually use the term "AHS" herein to refer to Empire and its relevant predecessor entities.

In the count of the complaint below which is here involved, Empire was a plaintiff as the real party in interest and to secure a complete adjudication.

BCBSA as the prime contractor was the nominal principal plaintiff.

BCBSA has no parent, and no affiliate, *i.e.*, no corporation under common ownership or control. Treating as "subsidiaries" all entities in which it has an ownership interest (other than solely for investment purposes) and/or power to designate one or more directors, the following are its subsidiaries: BCS Financial Corporation; Plans' Liability Insurance Company; BPS, Inc.; Business Systems Corporation of America; Dental Network of America; Health Information Reporting Company; Health Plans Capital Service Corporation; Plan Investment Fund, Inc.; National Account Service Company; Health Services Foundation; and Blue Shield Foundation on Health Care.

Empire has no parent, and no affiliate, *i.e.*, no corporation under common ownership or control. Treating as "subsidiaries" all entities in which it has any ownership interest (other than solely for investment purposes) and/or power to designate one or more directors, the following are its subsidiaries: Access America, Inc.; Administrative Services Network, Inc.; Beacon Corporate Benefit Services; BCS Financial Corp.; Dental Network of America, Inc.; Empire National Account Service Co., Inc.; Health Information Reporting Company; National Account Service Company; Plans' Liability Insurance Company; System Re Ltd.; Northeastern New York Health Care Consortium, Inc.; and Health Services Improvement Fund, Inc.

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Petitioners,

v.

THE UNITED STATES,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Empire Blue Cross and Blue Shield and Blue Cross and Blue Shield Association respectfully petition the Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Federal Circuit entered in this proceeding on June 21, 1988 (rehearing denied July 20, 1988).

I. PRELIMINARY MATTERS

A. Opinions Below

The opinion of the court below is unreported. It is reprinted at p. 1 of the Appendix to this Petition (hereinafter cited as "App.").

The order of the court below affirmed a judgment of the United States Claims Court. That court's opinion is reported at 13 Cl. Ct. 710 (1987), reprinted at App. 4.

In turn, the action in the United States Claims Court was, as far as is here material, a review of a decision by the Armed Services Board of Contract Appeals. It is reported at ASBCA No. 26529, 86-2 B.C.A. (CCH) ¶ 18,751, reprinted at App. 19.

B. Jurisdiction

The judgment below was dated June 21, 1988, and issued as a mandate July 27, 1988, after a timely petition for rehearing had been denied on July 20, 1988. Jurisdiction of this Court to review the case by writ of certiorari is conferred by 28 U.S.C. § 1254(1).

C. Constitutional Provisions and Statutes Involved

U. S. Const. Amendment 5

"No person shall ... be deprived of ... property, without due process of law.... ."

Wunderlich Act, § 1, 68 STAT. 81, 41 U.S.C. § 321

"No provision of any contract entered into by the United States, relating to the finality or conclusiveness of any decision of the head of any department or agency or his duly authorized representative or board in a dispute involving a question arising under such contract, shall be pleaded in any suit now filed or to be filed as limiting judicial review of any such decision to cases where fraud by such official or his representative or board is alleged: *Provided, however*, That any such decision shall be final and conclusive unless the same is fraudulent or capricious or arbitrary or so grossly erroneous as necessarily to imply bad faith, or is not supported by substantial evidence."

II. STATEMENT OF THE CASE

A. Basis for Federal Jurisdiction in the Court of First Instance

The court of first instance was the United States Claims Court, reviewing a decision of the Armed Services Board of Contract Appeals. It had jurisdiction of the action under 28 U.S.C. § 1491, and under both sections of the Wunderlich Act, 41 U.S.C §§ 321 and 322.

B. Facts Material to the Consideration of the Question Presented

Petitioner BCBSA contracted with the Health Care Financing Administration, an element of the Department of Health and Human Services, to pro-

vide administrative services in connection with the Medicare program. As the contracts contemplated, BCBSA subcontracted the actual work to member Blue Cross plans, including AHS. (Since only AHS's costs and activities are relevant to the case, for simplicity we will sometimes speak hereinafter as if AHS had been the direct contractor, had been the only plaintiff below, and were the only petitioner here.)

The contracts were on a cost-reimbursement, no-loss, no-profit, no-fee basis: *i.e.*, the government agreed to reimburse AHS for all its costs of performing the services contracted for (both direct costs and allocated shares of indirect costs), but without a fee or other additional compensation.

This case arose in a dispute over whether an allocated share of an assessment levied on AHS by the New York State Insurance Department was chargeable to the government as an allowable cost under the contracts. Under that assessment, the expenses of the state Insurance Department for each year were charged to all insurers doing business that was regulated by the Department (including AHS), with each insurer paying the proportion of the Department's total expenses which its premium income from regulated business bore to the total of all such insurers' premium income from such business.

The government's original position (sometimes called the "benefit theory") was that an allocated share of this assessment was not an allowable cost of the contracts because the assessment was mea-

sured only by AHS's private business and did not "benefit" the government. AHS contended that a share of the assessment was allowable because the assessment was a necessary cost of doing business as an insurer and hence of being able to carry out the contracts at all. Eventually the government dropped the "benefit theory," presumably recognizing that AHS's position was correct in light of the Court of Claims's decisions in *Lockheed Aircraft Corp.* v. *United States*, 375 F.2d 786 (Ct. Cl. 1967), and *Blue Cross Association* v. *United States*, 568 F.2d 1339 (Ct. Cl. 1978).

The government then fell back to a new position, sometimes called the "double recovery" theory. It now contended that AHS had already recovered the cost of the assessment from its premiums for private health insurance, and that reimbursement of AHS by the government would create an impermissible "double recovery." Hence, it still refused to reimburse AHS for Medicare's allocated share of the assessment.

The contracts contained "disputes clauses" of the customary type, under which an aggrieved contractor can appeal to the cognizant board of contract appeals. The Department of Health and Human Services does not maintain its own board of contract appeals, but utilizes the services of the Armed Services Board of Contract Appeals ("ASBCA"). AHS duly appealed to that board.

Before the ASBCA the government repeatedly represented that the only basis for its position was the "double recovery" theory.

Thus, in interrogatory answers filed well before the hearing it said that there was "**only one fact, namely whether or not the assessment has been recovered from another source**, that has been determinative of whether or not the government has considered the assessment as an allowable cost or not." App. 42 (emphasis added).

Again, in a prehearing stipulation it confirmed its abandonment of the "benefit theory," and said: "The government is not challenging this cost on a 'benefit' theory. That is, the government recognizes that if this cost were consistently treated as an indirect cost to all lines of business, the government would pay its *pro rata* share of the cost if it was not recovered through private premium business. **Rather, the government contends that such costs have been finally recovered from the subscriber premiums of AHS** ... and that under *Blue Cross Association* v. *United States*, 568 F.2d 1339 (Ct. Cl. 1978), this precludes their being charged as allowable costs to the contract in question." App. 43 (emphasis added).

And in his opening statement at the hearing, government counsel was explicit that the theory of his case was that Empire had already recovered the assessment from other business and that therefore for the government to pay a portion of it would constitute "double recovery":

> "MR. ROBBINS: ... Basically the way that the government has been handling this issue is its interpretation of the board's decision in the North Carolina case, which was upheld by the

> Court of Claims, and that is where the contractor **had not recovered this from other sources** the government has treated this as an allowable cost properly allocated to the contract, and has allowed recovery of these funds.
>
> "[If t]hrough investigation, audit, or otherwise, the government has found that the plan **had recovered the funds through its private subscription business**, ... then the government has denied recovery on the theory that once it has been charged directly to one source it can then not be charged indirectly and spread to all lines of business including the government.
>
> **"It is our contention that most, if not all of the money in the case before us now, Empire Blue Cross or Blue Cross Association, most of that money has been recovered already through its private subscription business**, and therefore, it is the government's position that it cannot now again be recovered through the government."

App. 46-47 (emphasis added; obvious errors in transcript corrected).

Accordingly, the case was tried for two days before an administrative law judge in a full evidentiary hearing devoted entirely to the question whether AHS had already recovered the cost and whether payment by the government of its allocated share of the assessment would result in "double recovery." Both sides presented witnesses and documentary evidence. As is usual before the ASBCA, post-hearing briefs (and, subsequently, reply briefs)

were filed by both sides simultaneously, rather than seriatim.

In its decision, issued February 5, 1986, the ASBCA never mentioned the issue of double recovery—the sole basis for the government's contention and the sole issue tried in the hearing. Instead, it denied AHS's claim on the basis that AHS was seeking to make an impermissible change in its accounting treatment of the assessment. This "changed accounting treatment" basis for refusing to reimburse AHS had never been raised by the government before or during the hearing and was entirely different from the "double recovery" theory on which the government had based its position before the hearing and on which the case was tried.

"Changed accounting treatment" is an established legal subject with a jurisprudence of its own in government contract law. If AHS had had notice before the hearing that this and not "double recovery" was the theory it would have to meet, its case could have concentrated heavily on the customary issues in a government "changed accounting treatment" claim, such as whether changed circumstances or inequitable results justified an accounting change (*e.g.*, *Zero Mfg. Co.*, ASBCA No. 14558, 70-2 B.C.A. (CCH) ¶ 8489; *Unidex Systems Corp.*, ASBCA Nos. 24, 85, 75-2 B.C.A. (CCH) ¶ 11,549)[1]—not to mention whether reimbursement of

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[1] In what seems to be a case of blaming the victim, the court below and the Claims Court in effect penalized the petitioners for failing to "show[] that continued use of [AHS's 'chosen accounting method'] would produce an unreasonable or inequitable result." App. 2 (court

the cost would indeed involve an "accounting change" within the meaning of this jurisprudence at all (Judge Bissell's point in the court below). It could have explored in greater depth the government's efforts to press AHS to follow the very practices on which the Board relied as evidence of an accounting "election" by AHS—an issue which was less significant to the "double recovery" issue and as to which the Claims Court observed that there was "little probative evidence in the record." App. 15. Moreover, in the exploration and presentation of all these issues, Empire would have had the help of the accounting officer primarily in charge of these matters, who was a key witness at the hearing and has since died.

The ASBCA's action was appealed by way of an action in the Claims Court. That court upheld the ASBCA. On the issue here involved (there were several others not here material), that court recognized two cases cited to it (*North Alabama Express, Inc.* v. *United States*, 585 F.2d 783, 786 (5th Cir. 1978), and *NLRB* v. *Quality C.A.T.V., Inc.*, 824 F.2d 542 (7th Cir. 1987))[2] as holding "that due process requires that interested parties be given reasonable notice of the claims of adverse parties and an

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below; see also App. 11, 14 (Claims Court). These are just the sorts of issues that the petitioners could have addressed had they been on notice before the hearing that the Board would treat the case as involving the "changed accounting treatment" principle notwithstanding that the government's only claim was "double recovery."

[2] The Claims Court did not even mention such fundamental cases cited to it as Morgan *v.* United States, 304 U.S.1 (1938), and Gonzales *v.* United States, 348 U.S. 407 (1955), both discussed *infra*.

opportunity to meet those claims." App. 13. It distinguished them on the ground that here, in the court's view, "plaintiffs are not arguing that the defendant failed to provide proper notice; rather, plaintiffs claim that the Board decided the case based on a theory different from that stipulated by the parties." And, said the court, "[e]ven if the Board's legal theory were novel, the Board is 'not precluded from deciding a claim on a theory not advanced by the parties.'" App. 13-14. It said that the "changed accounting treatment" theory was not "wholly novel" because it was "summed up" in the government's post-hearing brief before the Board. App. 12. And, it said, the pre-hearing stipulation "does not contradict this theory." App. 12.

On appeal, a panel of the United States Court of Appeals for the Federal Circuit affirmed the Claims Court 2-1. The three-sentence opinion of the panel majority (Judges Mayer and Michel) did not discuss the issue here presented, declaring simply that "[n]o circumstances here justify allowing Blue Cross retroactively to change the accounting treatment of the New York assessment." App. 2. Judge Bissell dissented, on the ground that "the Board and the Claims Court erred by improperly analyzing this case as though it involved a retroactive change of accounting method." App. 3. While she did not mention the issue here presented, the "improper[] analy[sis]" to which she referred would of course not have been possible had the ASBCA decided the case on the issue before it.

The panel of the court below denied rehearing on July 20, 1988. App. 37. On August 2, 1988, the court

below declined appellants' suggestion for rehearing in banc. Judge Bissell noted that she "would have the case reheard in banc." App. 39-40.

III. REASONS FOR ALLOWANCE OF THE WRIT

A. By Approving the Doctrine That an Administrative Tribunal Is Free To Decide After Hearing on a Basis Different From That on Which the Case Was Tried, the Court Below Has Sharply Deviated From the Principles of Due Process in Administrative Hearings Laid Down by This Court.

1. A Party to an Adjudicative Proceeding Is Entitled to Notice and an Opportunity To Present Evidence and Arguments With Respect to the Basis on Which the Government Acts to Its Detriment.

The standards of review of a decision after hearing by a board of contract appeals under the Wunderlich Act are "fraudulent or capricious or arbitrary or so grossly erroneous as necessarily to imply bad faith, or is not supported by substantial evidence." 41 U.S.C. § 321. These standards are the equivalent of constitutional due process. *Jonal Corp.* v. *District of Columbia*, 533 F.2d 1192, 1197-98 (D.C. Cir.), *cert. denied*, 429 U.S. 825 (1976). And "[i]n the administrative context, due process requires that interested parties be given a reasonable opportunity to know the claims of adverse parties"—and a fortiori those of the agency itself—"and an opportunity to meet them." *North Alabama Express, Inc.* v. *United States*, 585 F.2d 783, 786 (5th Cir.

1978). The court in *United States* v. *Bradt*, 291 F. Supp. 1022, 1023 (C.D. Calif. 1968), had to warn this very Board that it must accord "due notice, [and a] proper opportunity to be heard."

The principles of due process as declared by this Court do not permit a dispute between the government and a private party to be resolved, as this one was, on a basis advanced only after a hearing and without an opportunity to present evidence and associated arguments. In the oft-quoted words of Chief Justice Hughes in the seminal *Morgan II* case:

> "The right to a hearing embraces not only the right to present evidence but also a reasonable opportunity to know the claims of the opposing party and to meet them. The right to submit argument implies that opportunity; otherwise the right may be but a barren one. Those who are brought into contest with the Government in a quasi-judicial proceeding aimed at the control of their activities are entitled to be fairly advised of what the Government proposes and to be heard upon its proposals before it issues its final command."

Morgan v. *United States*, 304 U.S. 1, 18-19 (1938).

So important to fairness is the opportunity to meet contentions in advance, that this Court in *Gonzales* v. *United States*, 348 U.S. 407 (1955), held that due process was not satisfied by the opportunity to file a petition for reconsideration after the agency had acted. It there recognized what every experienced

lawyer knows, that once an agency has "gone public" with a decision it is very difficult to get it to admit error, and that therefore an opportunity to be heard only by way of reconsideration is "too little and too late" to satisfy due process requirements for a full hearing: "Too little, because the right to present petitioner's side of the case is broader than the bare right to correct 'errors' made by the Department in its recommendation." *Id.* at 417 (emphasis added).

The principle is as applicable to legal theories as to factual evidence. In the Court's catalogue of the elements of a fair hearing in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), prominently included was the requirement that "the decisionmaker's conclusion ... must rest solely on the **legal rules and evidence adduced at the hearing.**" *Id.* at 271 (emphasis added).

2. In Violation of This Principle, the Decision Below Approves an Administrative Tribunal's Deciding on a Basis as to Which the Parties Were Given No Pre-Hearing Notice or Opportunity To Present Evidence and Argument.

That the principles of due process as enunciated by this Court do not permit an agency to decide a contested matter in this fashion was raised, briefed, and argued by petitioners in the court below, and decided adversely to petitioners *sub silentio*. By suggestion for rehearing in banc, petitioners urged the court below to address the question explicitly, for the specific purpose of giving this Court the benefit of its articulated views; but, as noted, the suggestion was declined (Judge Bissell dissenting). The net ef-

fect of the unpublished opinion below is a summary affirmance of the Claims Court's decision, so that as a practical matter the Claims Court's opinion stands as the law of the Federal Circuit. And that law is plainly wrong.

As discussed *supra*, the Claims Court distinguished cases holding that due process requires that interested parties be given reasonable notice of the claims of adverse parties and an opportunity to meet those claims, on the ground that here petitioners were "not arguing that the defendant failed to provide proper notice; rather, [petitioners] claim that the Board decided the case based on a theory different than that stipulated by the parties." And, said the court, a board may decide a case on a novel theory not advanced by the parties. App. 13-14. Setting aside whether this accurately describes petitioners' argument (it does not), this is a singular distinction with no support in logic or the cases. The point is not whether it was the Board or opposing government counsel that failed to provide proper notice that petitioners would be judged on an "accounting treatment" basis. The point is that no such notice was provided from any quarter, so that appellants had no opportunity to present at the hearing evidence and arguments addressed to such a claim.[3]

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[3] The Claims Court distinguished William F. Klingensmith, Inc. *v.* United States, 731 F.2d 805 (Fed. Cir. 1984) (in which the Federal Circuit reversed a board for failure to address an issue before it) on the ground that in the case at bar "the Board fully explored the plaintiffs' claim." App. 13. This was an extraordinary statement, since the Board here never even reached, and the Claims Court said it did

As noted *supra*, the Claims Court took the view that the the "changed accounting treatment" theory was not "wholly novel" because such an approach was referred to (for the first time) in the government's post-hearing brief before the Board. App. 12. As to this it was in fact in error[4]; but even if it had been right, raising a novel basis at that stage, like the opportunity for rehearing in *Gonzales*, *supra*, is "too little and too late." See *Goldberg* v. *Kelly*, *supra*. Strongly in point are *NLRB* v. *Quality C.A.T.V., Inc.*, 824 F.2d 542 (7th Cir. 1987); *Stokeley-Van Camp, Inc.* v. *NLRB*, 722 F.2d 1324 (7th Cir. 1983); and *NLRB* v. *Homemaker Shops, Inc.*, 724 F.2d 535 (6th Cir. 1984), which, though they involve proceedings to enforce an NLRB order, deal with issues of arbitrariness, capriciousness, and due process identical to those involved in a Wunderlich review. These cases—discussed in more detail *infra* at pp. 17-19—all hold that due process does not permit the NLRB to decide a case on a basis raised by the General Counsel only after the hearing. They stand foursquare for the proposition that the due process defects of the Board's action here were not cured even if an "accounting treatment" argument had

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not have to reach, *ibid.*, the petitioners' key claim that there was and could here be no double recovery.

[4] The government's post-hearing brief did not address "changed accounting treatment" in customary terms at all, and cited none of the Board jurisprudence dealing with that subject. Its brief argued that AHS had actually recovered the cost, sometimes suggesting that the mere fact that the cost was included in the calculations on which private rates were based meant that it had been actually recovered. The table of contents of its brief referred simply to the proposition that "The State Assessment Has Been Recovered by the Plan Through Its Private Subscription Business." App. 48.

been made in the government's post-hearing papers.[5]

B. Over and Above the Conflict Between the Decision Below and the Decisions of This Court, the Question Whether an Administrative Tribunal May Decide After Hearing on a Basis Different From That on Which the Case Was Tried Is a Significant One Warranting This Court's Consideration.

1. The Question Is of Broad General Importance.

The issue presented is of broad general importance for at least two reasons.

First, even with respect only to boards of contract appeals, it is important to ensure that they, and the ASBCA in particular, stay clearly within the bounds of due process. Government contracts are all-pervasive in the modern economy; scores of billions of dollars' worth of such contracts are in effect; and many billions' worth of these are with elements of the Department of Defense, over which the ASBCA exercises its principal jurisdiction. It is as important to insure absolute propriety in the administration of disputes under these contracts as

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[5] Immaterial to the issue here presented are the Claims Court's view that the pre-hearing stipulation, in which the government confirmed its abandonment of the benefit theory and limited its contention to double recovery, "does not contradict" the changed accounting treatment theory, App. 12, and its puzzling statement that the stipulation made the changed accounting treatment theory "a necessary precursor to the issue of recovery." App. 14

it is to insure absolute propriety in the procurement process itself.[6]

Second, the issue presented is by no means limited to boards of contract appeals. It applies to adjudicative proceedings generally. It is fundamentally important that agencies be given clearly to understand that they are not free to decide cases on whatever theory may occur to them after the record is closed; that their decisions "must rest solely on the legal rules and evidence adduced at the hearing," *Goldberg* v. *Kelly*, *supra*, 397 U.S. at 271 ; that a litigant is entitled to present evidence on, and try, the issue on which the tribunal decides his case.

2. The Decision Below Effectively Places the Federal Circuit In Conflict With the Sixth and Seventh Circuits.

By holding that a tribunal may decide on a basis first raised after close of the hearing the decision below places the Federal Circuit in conflict, at least in basic principle, with the Sixth and Seventh Circuits. Thus, in *NLRB* v. *Homemaker Shops, Inc.*, 724 F.2d 535 (6th Cir. 1984), the court refused enforcement of an NLRB order where the NLRB had decided the case on a claim which, though it "f[e]ll within the same spectrum or continuum of unfair labor practices" as was claimed by the gov-

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[6] Most future cases will be governed not by the Wunderlich Act, as is this case, but by the Contract Disputes Act of 1978, 41 U.S.C. §§ 601-613. That statute provides a standard of review of decisions of boards of contract appeals identical to that of the Wunderlich Act. 41 U.S.C. § 609(b).

ernment before the hearing, 724 F.2d at 543, nevertheless was first raised in the government's post-hearing brief. Pointing to the fact that with adequate notice of this issue the company's counsel might well have presented a very different case at the hearing, the court said:

> "The fundamental fairness inherent in administrative due process cannot permit the General Counsel to plead a certain charge, insist at hearing that only that charge is being litigated, and then raise a related, but more onerous charge only after the hearing record is closed."

Id. at 543-44.

In *Stokeley-Van Camp, Inc.* v. *NLRB*, 722 F.2d 1324 (7th Cir. 1983), where the charge on which the NLRB's order was based "was not included in the original complaint, the complaint was never amended to reflect the charge, and Stokeley was first notified of the charge in the General Counsel's post-trial brief filed with the administrative law judge," the court said: "[W]e conclude that this was a clear violation of Stokeley's due process rights." 722 F.2d at 1331.

And in *NLRB* v. *Quality C.A.T.V., Inc.*, 824 F.2d 542, 547-48 (7th Cir. 1987), the government first raised a theory on appeal from the administrative law judge to the full NLRB. The court pointed out that the company's counsel "would have been much more concerned about a myriad of factual and legal issues" had the new theory been timely raised,

causing him to "take a different tack in his presentation of evidence and in his cross-examination of the government's witnesses." *Id.* at 547. Markedly similar considerations apply here, where if petitioners had had warning of any need to present "changed accounting treatment" evidence they would have had a very different case to present from what they actually presented on the understanding that the government's theory was "double recovery."

The net result is that in the Federal Circuit administrative tribunals may decide cases on grounds not raised before the hearing, while in the Sixth and Seventh Circuits they may not. This clear split in principle among circuits on a matter of such fundamental importance warrants grant of certiorari.

IV. CONCLUSION

Over and above correction of a specific injustice to the petitioners, this case affords the Court an opportunity to reaffirm the principles of due process and essential fairness in the resolution of disputes between private parties and the government, and to declare the bounds beyond which administrative agencies in adjudicative proceedings cannot go "on frolics of their own." In doing so, the Court will resolve a conflict in principle between the rule resulting from this case for the Federal Circuit on the one hand, and the rule already declared for the Sixth and Seventh Circuits on the other hand, with

respect to the propriety of an administrative tribunal's deciding a case on a basis not advanced by the government until after an adjudicative hearing.

Respectfully submitted,

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October 14, 1988

APPENDIX

APPENDIX A

Opinion of the Court Below

Note: This opinion has not been prepared for publication in a printed volume because it does not add significantly to the body of law and is not of widespread legal interest. It is a public record. It is not citable as precedent. The decision will appear in tables published periodically.

United States Court of Appeals for the Federal Circuit

88-1135

BLUE CROSS AND BLUE SHIELD ASSOCIATION
and
EMPIRE BLUE CROSS AND BLUE SHIELD,
Plaintiffs-Appellants,
v.
THE UNITED STATES,
Defendant-Appellee.

DECIDED: June 21, 1988

Before BISSELL, MAYER, and MICHEL, *Circuit Judges*.

PER CURIAM.

DECISION

The judgment of the United States Claims Court, 13 Cl. Ct. 710 (1987), is *affirmed* on the basis of the court's opinion.

OPINION

Blue Cross and Blue Shield Association consistently treated the New York Insurance Department assessment as a cost of its private subscription business; it included the entire assessment in its private premium rate structure; and it did not allocate or charge to the medicare program any portion of that assessment during the pertinent period. Because of the "commercial havoc" that would otherwise ensue, a contractor will generally be held to its chosen accounting method unless, as observed by the Claims Court, *id.* at 714, it shows that continued use of that method would produce an unreasonable or inequitable result. No circumstances here justify allowing Blue Cross retroactively to change the accounting treatment of the New York assessment.

[Repetition of caption and non-publication notice omitted in printing]

BISSELL, *Circuit Judge*, dissenting.

I dissent. Substantial evidence does not support the Board's finding that the New York Insurance Department assessment was a direct cost of the private business of American Hospital Services of New York (AHS). The record reveals that AHS treated

the assessment as an indirect cost of all business, but that AHS did not allocate a portion of this indirect cost against the government contracts at issue in this case until final settlement. In my view, therefore, the Board and the Claims Court erred by improperly analyzing this case as though it involved a retroactive change of accounting method. I would vacate and remand.

APPENDIX B

Opinion of the United States Claims Court

In the United States Claims Court

No. 355-86C

(FILED NOVEMBER 23, 1987)

BLUE CROSS AND BLUE SHIELD ASSOCIATION
and EMPIRE BLUE CROSS AND BLUE SHIELD
v.
THE UNITED STATES

(Portions of caption and appearances omitted in printing)

OPINION

MARGOLIS, Judge.

This dispute centers on a disagreement as to whether plaintiffs are entitled to be reimbursed for a specific cost under certain cost-reimbursement, no-fee contracts with the government. The Armed Services Board of Contract Appeals (ASBCA or Board) denied plaintiffs' claim for reimbursement. Plaintiffs now seek reversal of the Board's decision under the Wunderlich Act standards (Count I). Plaintiffs also set forth claims based on breach of contract (Count II), restitution (Count III), and an uncompensated taking of property (Count IV). Plaintiffs have filed a motion for partial summary judgment on Counts I, III, and IV, and seek

$905,576 plus interest in damages. Defendant has filed a cross-motion for summary judgment on all four counts. After a careful review of the Board's decision and the record, and after hearing oral argument, the plaintiffs' motion is denied, and the defendant's motion is granted.

FACTS

On June 16, 1966, the government and plaintiff Blue Cross and Blue Shield Association (BCBSA) entered into a contract pursuant to which BCBSA would act as an intermediary to perform certain administrative functions dealing with the Medicare program. The contract provided that BCBSA would administer the program on a "no-cost" basis, making neither a profit nor a loss, with the government paying BCBSA for its costs of administering the program. The contract allowed BCBSA to subcontract the performance of the services to local affiliates. In the southern New York area, BCBSA subcontracted to Associated Hospital Services of New York (AHS), which was later succeeded by plaintiff Empire Blue Cross and Blue Shield (Empire) on June 1, 1974.

The 1966 contract was superseded by a June 29, 1970 contract, which in turn was superseded by a July 1, 1973 contract that ran through June 30, 1975. The period at issue here extends from January 1, 1968 through May 31, 1974. New York state law empowers the New York Insurance Department, for the purpose of defraying its operating expenses, to levy assessments against insurance companies doing business in the state. *See* N.Y. Ins. Law § 332

(McKinney 1985) (formerly § 32-a). Each insurance company operating within the state is charged a *pro rata* share of the total amount required to operate the Insurance Department for the year. Each company pays a percentage of the total amount equal to that company's percentage share of the total premiums received by all insurance companies in the state that year. Although AHS was subject to this assessment, AHS did not allocate any portion of this assessment to its Medicare costs from the beginning of the contract in 1966 to May 1974. Instead, AHS took into account the entire state assessment when setting premium rates for its private subscribers.

When Empire took over AHS, it immediately began to allocate a portion of the state assessment to Medicare. During final settlement of its contracts with the government, Empire asserted that it was entitled to be reimbursed by the government for a percentage of the state assessment for the period extending from January 1, 1968 through May 31, 1974. This claim was denied, and plaintiffs appealed to the ASBCA. In its opinion dated February 5, 1986, the Board concluded that AHS had consistently identified and treated the New York assessment as a direct cost of its private subscription business; that AHS had not, during the period at issue, allocated any portion of the assessment to the Medicare program; and, that AHS could not retroactively change the accounting method it had employed to recover the cost of the assessment.

DISCUSSION

Count I: Wunderlich Act

The question faced by this court under Count I of the complaint is whether the decision the Armed Services Board of Contract Appeals should stand. Both parties agree that the Wunderlich Act principles apply to this court's review of the Board's decision. Plaintiffs strenuously argue that the Board's decision should be reversed, both because the Board based its decision on a novel theory different than the theory to which the parties stipulated, and because the Board made erroneous conclusions of law in applying the theory it used. Defendant contends that the Board did in fact properly rule on the stipulated issue.

Interpretation of a contract under the Wunderlich Act is a question of law for the court to decide; the administrative interpretation is not binding. *See* 41 U.S.C. § 322 (1976). Nevertheless, the Board's interpretation is entitled to careful consideration and will be accorded great respect if not unreasonable. *Dale Ingram, Inc.* v *United States*, 201 Ct. Cl. 56, 71, 475 F.2d 1177, 1185 (1973); *Shuey Aircraft, Inc.* v. *United States*, 3 Cl. Ct. 243, 245 (1983). Furthermore, the "factual determinations that form the basis of the Board's contract interpretation are entitled to finality if supported by substantial evidence." *Dale Ingram, Inc.*, 201 Ct. Cl. at 71, 475 F.2d at 1185; *Peterson-Sharpe Engineering Corp.* v. *United States*, 6 Cl. Ct. 288, 293 (1984).

In a Wunderlich Act case, the role of the Claims Court is not to determine whether the court would agree with each finding were the court to make the finding itself; rather, the court's inquiry is strictly limited to whether the Board's decision was supported by substantial evidence. See *Iconco* v. *United States*, 6 Cl. Ct. 149, 152-53 (1984), *aff'd*, 770 F.2d 179 (1985). A careful review of the Board's decision leads this court to the conclusion that the Board's factual determinations are supported by substantial evidence and that the Board's interpretation of the contract is not unreasonable. In preparation for the ASBCA hearing, the parties stipulated:

> The government is not challenging this cost on a "benefit" theory. That is, the government recognizes that if this cost were consistently treated as an indirect cost to all lines of business, the government would pay its *pro rata* share of the cost if it were not recovered through the private premium business. Rather, the government contends that such costs have been finally recovered from the subscriber premiums of AHS ... and that under *Blue Cross Association* v. *United States*, 568 F.2d 1339 (Ct. Cl 1978), this precludes their being charged as allowable costs to the contract in question. The appellants contend that *Blue Cross Association* v. *United States*, *supra*, is not applicable.

In its decision, the Board found that AHS "consistently treated the New York assessment as a cost of its private subscription business, allocating the cost entirely to its experience-rated and community-rated policies." The Board ruled that be-

cause AHS's accounting methods treated the cost as a direct cost and not as an indirect cost, the cost could "not be charged to the subject contracts either directly or indirectly." The Board concluded that "[i]t was Associated's obligation to choose on a prospective basis the accounting method to be employed for recovering the cost of the assessment... ." Because AHS chose to recover its costs by treating the entire assessment as a direct cost, the Board held that AHS was precluded from retroactively modifying its accounting method to allocate a portion of the assessment as an indirect cost.

The Board erred, plaintiffs argue, in deciding the case on a "wholly novel" theory different than the theory to which the parties stipulated. Plaintiffs contend that the only issue before the Board was whether government reimbursement would constitute "double recovery." Defendant believes that the plaintiffs read the parties' stipulation and the Board's decision far too narrowly. The defendant states that its position before the Board was that "pursuant to the terms of the contract which barred the charging to the Government of costs treated by [AHS] as direct costs of non-government business, AHS could not retroactively change its treatment of the assessment" because, once allocated as direct costs, those costs were recovered, and a change in plaintiffs' accounting methods would constitute a "double recovery" of the costs.

The question the Board faced was not whether AHS *could* have allocated the assessment as an indirect cost, but whether AHS *did* so allocate them. *See Blue Cross Association* v. *United States*, 215 Ct.

Cl. 400, 404, 568 F.2d 1339, 1341 (1978) (hereinafter *Blue Cross of North Carolina*). The Board found that AHS's chosen accounting method did, in fact, treat the assessment as a direct cost, therefore precluding allocation to the government contract.

While the Board's opinion does not squarely address the issue of double recovery, that alone does not provide grounds for reversal. While in *Blue Cross of North Carolina*, the Court of Claims investigated whether a recovery had been made, the reasoning of the Board's opinion in this case does not require an examination of whether plaintiffs had actually recovered the assessment in full. Plaintiffs are correct that the facts of this case differ from the facts in *Blue Cross of North Carolina*. The plaintiffs in that case charged the entire tax to their non-government business, while at the same time, for accounting purposes, their books allocated a portion of the tax as an indirect cost chargeable to the government. In the case at hand, AHS charged the assessment solely to its non-government business and, in line with that practice, AHS's accounting method treated the assessment as a direct cost. No portion of the assessment was allocated as an indirect cost chargeable to the government. The Board correctly recognized that plaintiffs, in effect, seek to change their accounting method retroactively to treat a portion of the assessment as an indirect cost chargeable to the government.

In *Blue Cross of North Carolina*, the ASBCA had to determine whether the contractor was entitled to recover under both methods of cost recovery—re-

covery of the entire tax as a direct cost together with recovery of an allocated portion of the tax as an indirect cost. The Board's decision in that case was that the tax could not be claimed as an indirect cost because it had already been recovered as a direct cost. 215 Ct. Cl. at 403-05, 568 F.2d at 1341. In the case at hand, because the Board found that AHS specifically identified the assessment as a direct cost of its private subscription business and that AHS did not allocate a portion of the assessment as an indirect cost, the Board did not have to determine whether the costs had actually been recovered as direct costs. Section 1-15.202 of each of the contracts specifically provides that costs identified specifically with other work of the contractor are direct costs of that work and are not to be charged to the contract directly or indirectly. In light of its factual findings, the Board properly interpreted the applicable language of the contracts. The Board ruled that because AHS's accounting method had specifically identified the assessment as a direct cost of its non-government business, AHS could not charge the assessment to the government. The Board further found that there were no inequities that justified AHS retroactively changing its method of accounting many years after the contracts were signed.

The Board's legal conclusion cannot be said to be unreasonable. The Board's well-settled rule is that a contractor will be held to its normal accounting method unless the contractor shows that continued use of that method produces inequitable results and that the use of a different method will produce equi-

table results. *Celesco Industries*, ASBCA No. 22402, 80-1 B.C.A. (CCH) ¶ 14,271 at 70,297; *Unidex Systems Corp.*, PSBCA Nos. 24, 85, 75-2 B.C.A. (CCH) ¶ 11,549 at 55,108; *Frederic Burk Foundation*, ASBCA No. 15728, 73-1 B.C.A. (CCH) ¶ 9959 at 46,738; *Zero Manufacturing Co.*, ASBCA No. 14558, 70-2 B.C.A. (CCH) ¶ 8489 at 39,460. The sole fact that the contractor has not recovered all of the costs that could be categorized as indirect costs "is an insufficient justification for permitting an accounting change which will result in recovery." *Unidex Systems Corp.*, 75-2 B.C.A. (CCH) at 55,109.

This court also agrees with the defendant that the Board's opinion is not founded on a "wholly novel" theory. In its post-hearing brief filed on September 12, 1985 before the ASBCA, the defendant summed up its theory. At the conclusion of that brief, the defendant asserted that AHS attempted to recover the entire assessment by treating the assessment as a direct cost of its private subscription business and included the entire assessment in its private premium rate structure. Therefore, the government argued, "[o]nce having made the election to so treat this cost, [plaintiff] cannot then turn around and treat it as an indirect cost, and attempt to charge a portion of it to the government's Medicare contracts." Brief at 14-15. This is exactly the theory upon which the Board rendered its decision. The stipulation of the parties does not contradict this theory. Rather, the determination of recovery under the stipulation is conditional upon the Board finding that the assessment was treated as an indirect cost. Because the Board concluded that AHS's

accounting method treated the assessment as a direct cost, the Board did not need to determine whether an actual recovery had been made.

To support the contention that the Board's application of a novel theory requires reversal, plaintiffs cite to a number of cases. *See National Labor Relations Board* v. *Quality C.A.T.V., Inc.*, 824 F.2d 542, 545 (7th Cir. 1987); *William F. Klingensmith, Inc.* v. *United States*, 731 F.2d 805, 807-08 (Fed. Cir. 1984); *North Alabama Express, Inc.* v. *United States*, 585 F.2d 783, 786 (5th Cir. 1978). However, none of these cases apply to the facts currently before this court. The *Klingensmith* case involved a Board's failure to address the plaintiff's claim. 731 F.2d at 807. In this case, the Board fully explored the plaintiffs' claim, but concluded that the plaintiffs had not shown a change in circumstances to justify a retroactive modification in the accounting method. Therefore, the Board never had to reach the issue of recovery.

Quality C.A.T.V. and *North Alabama Express* both hold that due process requires that interested parties be given reasonable notice of the claims of adverse parties and an opportunity to meet those claims so that the Board can decide the case based on a full litigation of the issues before it. See 824 F.2d at 545; 585 F.2d at 786. In this case, however, plaintiffs are not arguing that the defendant failed to provide proper notice; rather, plaintiffs claim that the Board decided the case based on a theory different than that stipulated to by the parties. Even if the Board's legal theory were novel, the Board is "'not precluded from deciding a claim on a theory

not advanced by the parties.'" *See Bruno Law* v. *United States*, 195 Ct. Cl. 370, 440 (1971) (quoting *L.B. Samford, Inc.* v. *United States*, 187 Ct. Cl. 714, 724, 410 F.2d 782, 787 (1969)).

In this case, plaintiffs were fully cognizant of defendant's position and had a reasonable opportunity to respond. It was plaintiff's burden to prove to the Board that special circumstances existed to justify a change in the accounting method. See *Zero Manufacturing Co.*, ASBCA No. 14558, 70-2 B.C.A. (CCH) ¶ 8489 at 39,460. Failing to meet this burden before the Board, the plaintiffs cannot now claim that the Board was required to decide the case based solely on the double recovery issue. The Board's decision not to address the double recovery issue, and instead to base its decision on a theory that was a necessary precursor to the issue of recovery, does not in any way require this court to upset the Board's decision. While a Board may be bound by the parties' stipulations of fact, the Board is not bound to accept the parties' stipulation of a legal theory. *See Bruno Law,* 195 Ct. Cl. at 440.

The plaintiff is correct that the contract allows the contractor to claim properly chargeable costs until a final closing agreement is effectuated. However, due to AHS's method of accounting, which treated the entire assessment as a direct cost, the assessment was not a cost properly chargeable to the government. As a result, only if AHS could retroactively change its method of accounting to allocate a portion of the assessment to the government would AHS be able to claim those costs in the final settlement. Because the Board re-

fused to allow a change in AHS's method of accounting, AHS could not claim the costs of the assessment during final settlement.

Without merit is the plaintiffs' claim that the defendant "tricked" the plaintiffs into not claiming the assessment initially and pressured, threatened and exerted duress on the plaintiffs. The court finds that there is little probative evidence in the record to support these contentions.

Further, plaintiffs' lengthy arguments do not convince the court that, on the record before the court, the Board's findings of facts are not supported by substantial evidence. The Board heard from Arthur Bettauer, an expert witness who was also Empire's chief financial officer and Walter A. Schaefer, who served as AHS's vice-president and treasurer during the period at issue. The Board also considered both AHS's internal accounting methods and the formulation of the rate structure as evidence that the assessment was treated as a direct cost. There was substantial evidence presented to the Board from which it could reach the conclusion that AHS included the entire cost of the assessment in its private rate proposals.

In light of the Board's conclusion that AHS consistently treated the assessment as a direct cost recoverable from its non-government business, the Board found there were no inequities that justified retroactively changing AHS's accounting method. While the Board may have elaborated to a greater extent in its analysis, this court concludes that the

Board's conclusion is not unreasonable, and, therefore, must be upheld.

Count II: Breach of Contract

Defendant has moved to dismiss this claim for lack of jurisdiction. Plaintiff has indicated that it included this count as a precautionary measure in case the dispute clauses of the contracts were held to be inapplicable. The plaintiff has no objection to this count being dismissed if the contracts' dispute clauses are applied. Because this court is applying the dispute clauses, the defendant's motion is granted, and Count II of the complaint is dismissed.

Count III: Restitution

Plaintiffs, on behalf of their subscribers, contend that the government's failure to pay a portion of the assessment has resulted in unjust enrichment, which, plaintiffs argue, requires the government to make restitution. This court cannot grant relief to plaintiffs under this count for two reasons. First, to the extent a claim for restitution is based upon an implied-in-law contract, rather than an implied-in-fact contract, the claim falls outside of the Claims Court's Tucker Act jurisdiction, 28 U.S.C. § 1491(a). In *United States Steel Corp.* v. *United States*, 210 Ct. Cl. 228, 241-42, 536 F.2d 921, 927 (1976), the Court of Claims held:

> [W]e do not have jurisdiction under the Tucker Act (28 U.S.C. § 1491) of claims based on a contract implied in law (as distinguished from

claims based on contracts implied in fact, which are within the jurisdiction of this court). Both the Supreme Court and this court have so held.

Plaintiffs attack the "ancient jurisprudence" upon which this restriction on this court's Tucker Act jurisdiction is based. While perhaps ancient in origin, the limitations on this court's jurisdiction over implied-in-law contracts has been repeatedly reaffirmed. *United States* v. *Mitchell*, 463 U.S. 206, 218 (1983); *Merritt* v. *United States*, 267 U.S. 338, 341 (1925); *Fincke* v. *United States*, 230 Ct. Cl. 233, 246-47, 675 F.2d 289, 296-97 (1982); *Porter* v. *United States*, 204 Ct. Cl. 355, 365 n.5, 496 F.2d 583, 590 n.5 (1974), *cert. denied*, 420 U.S. 1004 (1975); *Hirschmann* v. *United States*, 11 Cl. Ct. 338, 341 (1986).

Second, plaintiff cannot recover under this claim because "it is well settled that there can be no implied contract where there is an express contract between the parties," as there is here. *United States Steel Corp.*, 210 Ct. Cl. at 242, 536 F.2d at 928; *Peter* v. *United States*, 6 Cl. Ct. 768, 780 (1984). For an implied contract to be valid, it must be unrelated to the express contract. *Peter*, 6 Cl. Ct. at 780. Plaintiff's alleged implied contract is grounded on the same facts as the express contract between the parties. Therefore, for the reasons set forth above, Count III must be dismissed.

Count IV: Compensation for Taking

Plaintiffs' fourth count is a claim of taking, based upon plaintiffs' subscribers being forced to pay

higher premiums as a result of bearing the entire burden of the assessment costs. There is no taking here; the rights of the parties are strictly contractual. AHS made the initial decision as to the manner in which it would recover the costs of the assessment. The Wunderlich Act claim determined the extent of the defendant's duty to reimburse plaintiffs. If, as found here, the government has no contractual duty to reimburse plaintiffs, the failure to reimburse plaintiffs cannot be deemed a taking. There is no government taking of property involved in this case and, therefore, this count must also be dismissed.

CONCLUSION

The ASBCA decision was supported by substantial evidence and was not unreasonable. Accordingly, this court will not upset the Board's decision, and the defendant's motion for summary judgment on Count I is granted. Also, for the reasons stated above, defendant's motion for summary judgment on Counts II and IV is granted. Defendant's motion to dismiss Count III for lack of jurisdiction is also granted. The plaintiffs' motion for partial summary judgment is denied. The Clerk will dismiss the complaint. Each party will bear its own costs.

/s/ Lawrence S. Margolis
LAWRENCE S. MARGOLIS
Judge, U.S. Claims Court

November 23, 1987

APPENDIX C

Opinion of Armed Services Board of Contract Appeals

Appeal of Blue Cross and Blue Shield Association

ASBCA No. 26529

86-2 B.C.A. (CCH) ¶ 18,751

ARMED SERVICES BOARD OF CONTRACT APPEALS

Appeal of —

Blue Cross and Blue Shield Association

Under Contract Nos SSA-66-001-1
SSA-70-001-1
SSA-73-001-1

[Appearances omitted in printing]

OPINION BY ADMINISTRATIVE JUDGE SPECTOR

This is an appeal from a decision dated 1 September 1981 determining that certain assessments imposed under the New York Insurance Law were unallowable. Only entitlement is in issue.

FINDINGS OF FACT

1. Appellant is a not-for-profit corporation organized and existing under the laws of the State of Illinois. It was previously known as Blue Cross Association, the name having been changed on 1 July 1982.

2. At all times here material appellant was an association of Blue Cross Plans; nonprofit organizations located throughout the United States which furnish hospital and health-related benefits to subscribers and other covered persons (stip. 5).

3. The subject contracts were cost reimbursement, no-fee contracts entered into between the Secretary of Health, Education and Welfare (subsequently the Secretary of Health and Human Services) and appellant, which required appellant to administer and facilitate payments under what is popularly known as the Medicare program (complaint & answer, ¶ 2).

4. Contract No. SSA-66-001-1 was executed on 16 June 1966. It set forth the terms and conditions of an agreement pursuant to which appellant agreed to act as an "intermediary" to perform certain functions in connection with the administration of Part A of Title XVIII of the Social Security Act, as amended, in accordance with the provisions of Section 1816 of the Social Security Act, 42 U.S.C. § 1359h. It remained in effect until it was superseded by Contract No. SSA-70-001-1, effective 1 July 1970. (Stip. 11)

5. Contract No. SSA-70-001-1 was executed on 29 June 1970. It superseded Contract No. SSA-66-001-1 effective 1 July 1970 and continued in effect until superseded by Contract No. SSA-73-001-1 effective 1 July 1973. It likewise set forth the terms and conditions pursuant to which appellant agreed to act as an "intermediary" to perform certain functions in connection with the administration of Part A of Title XVIII of the Social Security Act. (Stip. 12)

6. Contract No. SSA-73-001-1 was executed on 3 August 1973. It superseded Contract No. SSA-70-001-1 effective 1 July 1973, and continued in effect at all remaining times relevant to this appeal. It likewise set forth the terms and conditions pursuant to which appellant agreed to act as an "intermediary" to perform certain functions in connection with the administration of Part A of Title XVIII of the Social Security Act. (Stip. 13)

7. Part A of Title XVIII of the Social Security Act provides for a portion of the federal Medicare program of health insurance. In general, Part A deals with insurance for hospitalization and related covered services. An "intermediary" under Part A is a non-government entity which contracts with the Government to provide certain services in connection with the administration of Part A. (Stip. 14)

8. The contracts incorporated certain cost principles to be employed in determining allowable costs, including § 1-15.202 of the Federal Procurement Regulations. As in effect on the date of execution of the first two contracts referenced above this section stated in part:

§ 1-15.202 Direct costs.

(a) A direct cost is any cost which can be identified specifically with a particular cost objective. Direct costs are not limited to items which are incorporated in the end product as material or labor. Costs identified specifically with the contract are direct costs of the contract and are to be charged directly thereto. Costs identified specifically with other work of the contractor are direct costs of that work and are not to be charged to the contract directly or indirectly.

At the time of execution of the third contract, the section stated in part:

§ 1-15.202 Direct costs.

(a) A direct cost is any cost which is identified specifically with a particular final cost objective (see § 1-15.109(f)). No final cost objective shall have allocated to it as a direct cost any cost if other costs, incurred for the same purpose in like circumstances, have been included in any indirect cost pool to be allocated to that or any other final cost objective. Costs identified specifically with the contract are direct costs of the contract and are to be charged directly thereto. Costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objective and are not to be charged to the contract directly or indirectly.

9. The contracts provided for appellant to submit to the Government (a) at such times and in such form as the Government might determine budgets of administrative expenses to be incurred during a given year, (b) quarterly reports of incurred administrative expenses, and (c) on an annual basis final administrative cost proposals for administrative costs incurred that year.

10. The contracts allowed appellant to enter into subcontracts with Blue Cross Plans (i.e., local Blue Cross organizations) to perform some of the specified functions.

11. By agreement executed 14 September 1966 appellant subcontracted to Associated Hospital Services of New York (hereinafter "Associated," a Blue Cross Plan) the performance of various functions under Contract No. SSA-66-001-1, effective 1 July 1966 to 30 June 1970 (stip. 16).

12. By agreement executed 19 April 1971 appellant subcontracted to Associated the performance of various functions under Contract No. SSA-70-001-1, effective 1 July 1970 to 30 June 1973 (stip. 17).

13. By agreement executed 14 September 1973 appellant subcontracted to Associated (which on 1 June 1974 was succeeded by Empire Blue Cross and Blue Shield, hereinafter "Empire") the performance of various functions under Contract No. SSA-73-001-1, effective 1 July 1973 to 30 June 1975. Empire is the successor to all rights and obligations of Associated so far as the instant appeal is concerned. (Stips. 2, 18)

14. Associated offered to its private subscribers both community-rated and experience-rated health insurance policies. The original Blue Cross concept was for basically everyone to pay the same rate, which is known as community rating. In 1944, however, Associated started to offer experience-rated policies as well under which the premium rates were determined by a particular group's actual experience rather than by the community as a whole. At the time of the hearing of this appeal in June 1985 Empire's premium income was about equally split between community and experience-rated policies. (Tr. 1/121-23; R4, tab 39)

15. Advance approval from the New York State Insurance Department was not required for the setting of premium rates for experience-rated policies, although the Department reviewed Associated's "general experience rated contract form" and basically did "examine the overall experience rated business in gross to insure that the total volume of business covers" its cost and contributed about a one percent subsidy to the community-rated policies (tr. 1/30-32).

16. Premium rates for community-rated policies are "regulated directly" by the New York State Insurance Department. They must be approved by the Department before they are charged, and cannot be changed without the Department's prior approval. (Tr. 1/29, 31, 51) Mr. Bettauer, Empire's chief financial officer, testified with respect to the procedure employed as follows:

A. We file an application for a rate increase. We present data on our present rates and on the proposed rates we give financial history data, and we estimate the impact of the proposed rates and project forward for a period that will restore the reserve level to 5%. We present the data showing how that will be accomplished.

Q. Then is there a hearing procedure?

A. Yes, there is a notice of hearing, and there are, I believe, at least two public hearings. When the decision is made, there is a 30 day public notice, and then the rates are allowed to go into effect.

Q. Does the insurance department issue written opinions with it's decision on the rate increase application?

A. Yes, it's known as an opinion and decision.

(Tr. 1/51-52)

17. The Board's record indicates the following comparison between the amounts of rate increases requested for community-rated policies by Associated and the New York State Insurance Department's action on such requests:

Request Date	Rate Increase Requested by Associated	Rate Increase Approved by Department
2/28/64	34.8%	32.9%
5/22/69	49.5%	43.3%
1/15/71	19.3%	17.8%
2/8/72	17.9%	14.8%
1/16/73	9.3%	7.4%

(R4, tab 40; tr. 1/53-56; exhs. A-1, -3, -5, -7, -9)

18. Associated was a nonprofit corporation, having no stockholders. It was incorporated in 1934. In the event of liquidation "the capital or reserve for the protection of [its] customers would be disposed of by one of the state courts." (Tr. 1/27-28, 45, 59-60; exh. G-1) It was organized and operated under former Article IX-C of the New York Insurance Law which stated in Section 256:

> 3. Every such corporation heretofore incorporated shall maintain a reserve, to be designated as the statutory reserve fund, which shall from time to time during each calendar year be increased in an amount equal to at least one per centum of the net premium income of such corporation during such whole calendar year, provided however, that: . . . (ii) the statutory reserve fund at the end of any calendar year shall not exceed five per centum of the net premium income of such calendar year; . . . .(Tab 36)

19. With respect to the statutory reserve fund, Mr. Bettauer testified:

A. Our basic financial planning revolves around that 5%; that is if our reserve level is below that 5% point we try to build up toward it by seeking higher rates, and if our reserve level is above the 5%, we do not ask for rates and we allow inflation to catch up with us until that level drops to 5%. At which time, as soon as we could, we would like to seek additional rate relief.

I would hope that at some point we could convince the legislature to raise that level to 10%, but nothing has been done in that direction.

(Tr. 1/46)

20. Pursuant to Section 32-a of the New York Insurance Law, Associated was required to pay an annual assessment to defray the operating expenses of the New York Insurance Department (complaint & answer, 5). Section 32-a provided that the excess of the expenses of the Department over the amount of fees and refunds collected and paid into the state treasury was to be:

assessed by the superintendent pro rata upon all domestic insurers and all licensed United States branches of alien insurers domiciled in this state . . . in proportion to the gross direct premiums or other considerations, written or received by them in this state during the calendar year ending December thirty-first immediately preceding the end of the fiscal year or the abridged fiscal year for which the assessment is made (less return premiums or considerations thereon) for policies or contracts of insurance

> covering property or risks resident or located in this state the issuance of which policies or contracts requires a license from the superintendent; and the superintendent shall levy and collect such assessments and pay the same into the state treasury. . . .

(Complaint & answer, 5; R4, tab 35)

21. For the period 1 January 1968 - 31 May 1974 Associated incurred assessments on account of Section 32-a of the New York Insurance Law in the aggregate amount of $6,721,803 (R4, tab 32).

22. Associated filed annual statements with the New York State Insurance Department, giving a detailed report of its operations. In these statements Associated set forth the amount of the expense incurred by it for the New York assessment for the period being reported on. (Tr. 1/32, 142-44; exh. G-1)

23. Associated's rate increase requests for community-rated policies filed with the New York Insurance Department also contained a large quantity of financial data, such as amounts of administrative costs (including the New York assessment) previously incurred by it and amounts projected in the future by Associated for such costs. The financial data allocated those costs, in their entirety, to Associated's experience-rated and community-rated policies (exhs. A-1, -3, -5, -7, -9; tr. 2/19).

24. In arriving at its rate submissions for community-rated policies, Associated included its administrative costs. "[A] combination of the cost of benefits and the administrative costs determined the premium need that we filed with the regulator." (Tr. 1/140-41) Administrative costs were treated similarly by Associated in determining its rates for experience-rated policies (tr. 1/147).

25. During the span 1 January 1968 - 31 May 1974 Associated did not allocate or charge to the Government's Medicare program any portion of the New York assessment. For this period no receivable was set up against the Government for the assessment on Associated's financial records. (Tr 1/37-38, 76, 105, 129-30, 2/45-46, 52, 64-65; app's brief, pp. 39-40) Associated had positive net income for some intervals of time during the period, whereas for others there was a net loss (exhs, G-1, -3, -4, -5, A-3, -5, -9).

26. A former Vice-President and Comptroller of Associated testified:

> A. When Medicare began in 1966 there was no discussion of the insurance department assessment. Indeed, of the administrative costs of Associated Hospital Service in New York, the total Medicare Administrative costs was something in the neighborhood of 5 to 7%. The assessment issue had to be a very insignificant piece.
>
> Earlier on there were no specific rules as to what could be included and what could not be

included. We could not go to a piece of paper. What we did work out was arrangements whereby H.E.W. audit agent came in and reviewed us periodically.

Q. Did there come a time when representatives of H.E.W. expressed to you or the people reporting to you their views as to how it should be treated?

A. I do not believe that that took place until sometime in 1972 when the fiscal 1973 budget was being prepared, and I believe that my people reported to me that at the conference on the pre-budget discussions, rules and regulations that they were informed that the budget should not contain a provision for assessment—insurance department assessment.

(Tr. 1/137-38)

27. In a final administrative cost proposal dated 16 April 1975 filed for the year 1974, Associated charged the Government's Medicare program with miscellaneous costs in the amount of $478,254, of which some unspecified portion was for the New York assessment (R4, tab 33).

28. By Closing Agreements executed on 21 January 1977 appellant (on behalf of Associated) and the Government agreed to the administrative costs due under the Medicare program for the period 1 January 1968 - 31 May 1974, subject to the following concerning the New York assessment:

(c) Certain state taxes have been excluded in the total amount herein agreed to by the Secretary and the Intermediary, notwithstanding the Intermediary's position that such taxes are allowable as costs under the terms of the agreement between the Intermediary and the Secretary. If it is finally determined by competent authority that such taxes are allowable costs, a claimed amount, subject to audit, will be paid to the Intermediary. Otherwise, no payment will be due and the agreed costs as shown on the Closing Agreement will be final. Execution of this Closing Agreement is not to be construed as demonstrating the Intermediary's concurrence in the non-allowability of certain state taxes.

(R4, tab 7)

29. By letter to the Government dated 19 July 1977, Associated, responding to a questionnaire of the Government, stated in part:

Our rate filings to the regulatory authorities have not been prepared detailing the Insurance Department Assessments, nor for that matter, any specific component of our expense and accordingly, only total costs find their way into the specific rates requested.

(R4, tab 20)

30. Under date of 1 September 1981 the Government issued its decision on the New York assessment, determining that the New York as-

sessment in question was not allowable (R4, tab 8). Appellant took the subject appeal from this decision (R4, tab 9).

DECISION

We have said that contractors are entitled to adopt their own accounting systems provided they conform to generally applicable accounting principles and are consistently applied. *Hurd-Darbee, Inc.*, ASBCA No. 12928, 68-2, BCA ¶ 7402.

In the instant appeal, Associated, in its rate increase requests filed with the New York Insurance Department, consistently treated the New York assessment as a cost of its private subscription business, allocating the cost entirely to its experience-rated and community-rated policies. During the pertinent period (1 January 1968 - 31 May 1974) it did not allocate or charge to the Government's Medicare program any portion of the assessment. Both in arriving at its rate submissions for community-rated policies and when determining rates for experience-rated ones the assessment was included by Associated as a cost solely to be borne by its policy holders.

It is evident that for the period in question the assessment was identified specifically by Associated with its private subscription business. Consequently, pursuant to § 1-15.202 of the cost principles incorporated into the contract, the cost was a direct cost of that business and not to be charged to the subject contracts either directly or indirectly.

Appellant, in effect, wishes to change retroactively the method of accounting for the assessment. Although the revised method if it had been adopted initially might well have been acceptable and proper, no justification exists for selecting this particular item of cost on an ex post facto basis for special treatment. To do so would be inconsistent with Associated's accounting system and not in conformity with generally accepted accounting principles. Neither appellant nor the Government (in the absence of some possible peculiar circumstance not present here) may retrospectively change the accounting treatment of an item of cost to the prejudice of the other. The commercial havoc which could otherwise ensue is obvious. *Reynolds Metals Co.*, ASBCA No. 7686, 1964 BCA ¶ 4312, *recon.* 1964 BCA ¶ 4477; *Hurd-Darbee, Inc., supra*; *Borg-Warner Corp., Ingersoll-Kalamazoo Division*, ASBCA Nos. 9144 & 9145, 1964 BCA ¶ 4507, *recon.* 65-1 BCA ¶ 4622. *Cf. Bermite Division of Tasker Industries*, ASBCA No. 18280, 77-1 BCA ¶ 12,349, *recon.* 77-2 BCA ¶ 12,731; *Blue Cross, Blue Shield of North Carolina*, 76-2 BCA ¶ 12,112, *aff'd* 568 F.2d 1339 (Ct. Cl. 1978).

Appellant appears to argue that Associated's failure to allocate any of the assessment to the Medicare program was not "deliberate," citing the assessment's "insignificant" size at the beginning of the program and hearsay testimony to the effect that in 1972 the Government instructed that the 1973 budget not provide for it. This contention has no merit. It was Associated's obligation to choose on a prospective basis the accounting method to be em-

ployed for recovering the cost of the assessment notwithstanding its size or the Government's position on the matter. During the entire pertinent period (after as well as before the 1973 budget) the cost was consistently treated by Associated as a direct cost of its private subscription business; no charge for the assessment being made against the Government's Medicare program. No change of circumstances is presented to justify the retroactive modification of this established accounting practice as proposed by appellant.

The appeal must be, and hereby is, denied.

Dated 5 February 1986

/s/ Alan M. Spector
ALAN M. SPECTOR
Administrative Judge
Member of the Armed
Services Board of Contract
Appeals

I concur

/s/ Daniel M. Arons
Administrative Judge
Acting Chairman,
Armed Services
Board of Contract
Appeals

I concur

/s/ William J. Ruberry
Administrative Judge
Vice Chairman,
Armed Services
Board of Contract
Appeals

APPENDIX D

Judgment Sought To Be Reviewed

United States Court of Appeals for the Federal Circuit

88-1135

BLUE CROSS AND BLUE SHIELD ASSOCIATION
and
EMPIRE BLUE CROSS AND BLUE SHIELD,
Plaintiffs-Appellants,
v.
THE UNITED STATES,
Defendant-Appellee.

Judgment

ON APPEAL from the United States Claims Court *in CASE NO(S).* 355-86C
This CAUSE having been heard and considered, it is
ORDERED and ADJUDGED:

AFFIRMED.

ENTERED BY ORDER OF THE COURT

DATED Jun 21 1988 /s/ Francis X. Gindhart
Francis X. Gindhart, Clerk

ISSUED AS A MANDATE: July 27, 1988

Costs: Against; Appellant
Printing $212.48
Total $212.48

APPENDIX E

Order Denying Rehearing

Note: This opinion has not been prepared for publication in a printed volume because it does not add significantly to the body of law and is not of widespread legal interest. It is a public record. It is not citable as precedent. The decision will appear in tables published periodically.

United States Court of Appeals for the Federal Circuit

88-1135

BLUE CROSS AND BLUE SHIELD ASSOCIATION
and
EMPIRE BLUE CROSS AND BLUE SHIELD,
Plaintiffs-Appellants,
v.
THE UNITED STATES,
Defendant-Appellee.

Before BISSELL, MAYER, and MICHEL, *Circuit Judges*.

ORDER

A petition for rehearing having been filed in this case,

UPON CONSIDERATION THEREOF, it is

ORDERED that the petition for rehearing be, and the same hereby is, denied.

The suggestion for rehearing in banc is under consideration.

FOR THE COURT:

/s/ Francis X. Gindhart
Francis X. Gindhart, Clerk

7/20/88
Date

APPENDIX F

Order Declining Suggestion for Rehearing In Banc

Note: This opinion has not been prepared for publication in a printed volume because it does not add significantly to the body of law and is not of widespread legal interest. It is a public record. It is not citable as precedent. The decision will appear in tables published periodically.

United States Court of Appeals for the Federal Circuit

88-1135

BLUE CROSS AND BLUE SHIELD ASSOCIATION
and
EMPIRE BLUE CROSS AND BLUE SHIELD,
Plaintiffs-Appellants,
v.
THE UNITED STATES,
Defendant-Appellee.

ORDER

A suggestion for rehearing in banc having been filed in this case,

UPON CONSIDERATION THEREOF, it is

ORDERED that the suggestion for rehearing in banc is declined.

Judge Bissell would have the case reheard in banc.

FOR THE COURT:

/s/ Francis X. Gindhart
Francis X. Gindhart, Clerk

8/2/88
Date

APPENDIX G

Excerpt from Government's Answers to Interrogatories in ASBCA Proceeding, Appendix below, pp. 2104-2105

Interrogatory 15. If the answer to Interrogatory 14 is other than an unqualified negative, for each instance in which any portion of the Assessment was deemed by you to be an allowable cost incurred by any other New York plan:

(a) Identify the other New York plan involved.

(b) State the amounts of the assessment deemed to be an allowable cost.

(c) State each fact which you contend shows why the assessment is an allowable cost incurred by such other New York plans in such instances, but is not an allowable cost incurred by Appellant.

(d) ***

(e) ***.

[Answers:]

(a) The other New York plans are identified as part of 15(b).

(b) Enclosed is a breakdown of the New York State Plans. The period refers to the period covered by a particular audit that has resulted in a closing agreement. The amount "allowed" refers to three cases where the contractor held the money pending

the outcome of this issue; the amount "disallowed" refers to the amount of the assessment identified where the government held the money pending the outcome of this issue. It may be noted that in Rochester, for both Blue Cross and Blue Shield, the contractor has now been paid the money "disallowed" because it was determined that no "double recovery" took place. In the other plans, there was no attempt to recover the money held by the contractor, again because a determination was made that no "double recovery" took place. The GHI situation is the only other situation (other than BCBSGNY [Petitioners' note: *i.e.*, Blue Cross and Blue Shield of Greater New York, now Empire Blue Cross and Blue Shield],) which has not been resolved.

(c) There is only one fact, namely whether or not the assessment has been recovered from another source that has been determinative of whether or not the government has considered the assessment as an allowable cost or not. (Effective in the contract October 1, 1980, this issue has been administratively handled by contract clause for cost-reimbursement contracts; it is not a factor in fixed price contracts.)

(d) ***.

(e) ***.

APPENDIX H

Excerpt From Prehearing Stipulation in ASBCA Proceeding, Appendix below, pp. 2100-2101

20. The government is not challenging this cost on a "benefit" theory. That is, the government recognizes that if this cost were consistently treated as an indirect cost to all lines of business, the government would pay its *pro rata* share of the cost if it was not recovered through private premium business. Rather, the government contends that such costs have been finally recovered from the subscriber premiums of AHS and UMS and that under *Blue Cross Association* v. *United States*, 568 F.2d 1339 (Ct. Cl. 1978), this precludes their being charged as allowable costs to the contract in question. The appellants contend that *Blue Cross Association* v. *United States*, *supra*, is not applicable. Further, they do not by entering into this stipulation waive any position they may take with respect to that case in the event of an appeal.

APPENDIX I

Opening Statements in ASBCA Hearing, Tr. 1-5 to Tr. 1-8, Appendix below, pp. 1065-1068

[Tr. 1-5]

MR. HOLT: I'll make just a very brief opening statement for the record.

JUDGE SPECTOR: All right.

MR. HOLT: The appeals here involved are so called intermediaries or carriers of an excellent [*sic*; should probably be "of the federal"] medicare program. These are organizations who perform services in connection with the administration of the medicare program part A for hospital insurance, and part B for medical coverage.

Under contract with the government, under a cost-plus-no-fee arrangement, what is here involved is the allowability of an allocated portion of the New York State Insurance Department assessment levied on Empire and it's [*sic*] predecessors.

I think it is fair to say that there is no [Tr. 1-6] issue here of allocability in the sense of benefit to the government. The government has stipulated that this cost would be allocable and allowable under different circumstances from those which I think the record will develope [*sic*].

The question is whether they're allowable under the circumstances that the record will develope

[*sic*]. Our understanding of the government's contention is that because the charges for these assessments were defrayed by payments made from funds derived from sources other than Medicare reimbursement that to allow them as cost in the Medicare reimbursement would be a so called double recovery.

The appellant's [*sic*] contend, among other things, that there is no so called double recovery here involved and because of the nature of the corporations as non-profit entities and because of state law mandating both the nonprofit status and the maintenance of a statutory reserve, so that when the government does pay the cost, that would simply relieve a burden that the appellant's subscribers have borne.

In a very real sense, we see it as an unjust enrichment case and not as a double recovery case. The government relies strongly on the North Carolina case reported in the code of claims [*sic*] at 568 F 2nd 1339, and we [Tr. 1-7] think a quite different set of facts was presented here. Thank you.

JUDGE SPECTOR: Mr. Robbins, do you have anything?

MR ROBBINS: Yes, I would just like to briefly set this issue in perspective.

This issue first surfaced during the mid 70's but if costs involves this litigation [*sic*], as an example, contracts go back nearly to the inception of the Medicare program. Indeed it is a nationwide issue.

In somewhat of less of half [*sic*] of the states, I think 23, this issue has surfaced. The hearing today is basically the last hearing on this topic. All of the other plans—throughout the country it has been resolved through litigation, but most often through a settlement, and this issue has been resolved.

There is one other plan, G.H.I., and it's also in New York, and it is my understanding that their position is that they will abide by the ruling in this case. So, essentially, this is the last case to be heard on this issue.

Basically the way that the government has been handling this issue is it's [*sic*] interpretation of the board's decision in the North Carolina case, which was upheld by the court of claims, and that is where the [Tr. 1-8] contractor has not recovered this from other sources. [*sic*; should probably be no period] The government has treated this as an allowable cost properly allocated to the contract, and has allowed recovery of these funds.

Through [*sic*; probably should be "If through"] investigation, audit, or otherwise, the government has found that the plan had recovered the funds through it's [*sic*] private subscription business, and [*sic*; probably should be omitted] then the government has denied recovery on the theory that once it has been charged directly to one source it can then not be charged indirectly and spread to all lines of business including the government.

It is our contention that most, if not all of the money in the case before us now, Empire Blue

Cross or Blue Cross Association, most of that money has been recovered already through it's [*sic*] private subscription business, and therefore, it is the government's position that it cannot now again be recovered through the government.

JUDGE SPECTOR: I suppose we are ready for your first witness, Mr. Holt.

APPENDIX J

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